April Wright, MA, MFTI #69624
Supervised by Lea Roussos, LMFT #38398
1460 7th Street Suite 206
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(424) 258-5416

Date: ___________________ Print Name: ____

This document contains important information about my professional services and business policies. Please read it carefully and note any questions you might have so you can discuss them with me.

Qualifications
I earned a Masters in Clinical Psychology from Antioch University in Los Angeles, California. I am currently registered as a Marriage and Family Therapist Intern by the California Board of Behavioral Sciences, #IMF 69624. The California Board of Behavioral Sciences is located at 1625 North Market Blvd, Suite 200, Sacramento, CA 95834, (916) 574-7830.

Procedures
During your initial evaluation, several decisions have to be made: I will have to decide if I can provide the services needed to treat your presenting problem(s), you as a client have to decide if you are comfortable with me, and both of us have to decide on your goals for therapy and how to best achieve them. If you have questions about any of the procedures recommended, feel free to discuss these openly with me. If you decide to seek services with me, I will usually schedule one 50 minute session per week at a mutually agreed upon time (under some special circumstances sessions may be longer or more frequent).

Fee-Related Issues
My fee is $125.00 per 50 minute session. You will be expected to pay for each session at the time that it is held, payable to April Wright, M.A. I understand that personal schedules change, however your appointment time has been reserved for you and without proper notice it becomes difficult to replace the appointment with another patient. Once your appointment hour is scheduled, you will be expected to pay for it (even if it is missed) unless you provide 24-hours advance notice of cancellation.

If you have insurance, you will be provided with an insurance statement to submit to your insurance company. I am not a contracted provider with any insurance company. Services are not rendered on the basis that your insurance company will reimburse you. You (not your insurance company) are responsible for full payment of the fee. I reserve the right to periodically adjust my fee. Clients will be notified of any fee adjustment in advance.

From time-to-time, I may engage in telephone contact with clients for purposes other than scheduling sessions. Clients are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 15 minutes. In addition, from time-to-time, I may engage in telephone contact with third parties at a client's request and with a client's advance written authorization. The client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 15 minutes.

Confidentiality
In general, the law protects the confidentiality of all communications between a client and a therapist, and I can release information to others about your therapy only with your written permission (in the form of a Release of Information), except where required or permitted by law. In addition, professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding my clients.

Some exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, safety emergencies when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.

Availability
I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis service. In the event that a client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Physical Health
Psychological disorders and symptoms often have a strong correlation with medical illnesses. At times, some medical conditions require a medical differential diagnosis to determine symptom etiology. If your presenting symptoms are organic in origin, it is critical that you obtain medical treatment. Therefore, if you have not had a physical in the last 6 months it is recommended that you do so. In addition, prescription and nonprescription medications may have significant side effects that may be important for us to consider. I expect full disclosure of all medicines and drug intake and may request a Release of Information so that I can coordinate therapeutic services with your physician or other appropriate health care providers.

Social Media
I am aware of the added convenience of text messages and email as a form of communication. It is important for you to know that these methods of communication are not completely secure or confidential. Internet Service Providers may retain logs of email and/or text communications. Any emails I receive from you and any responses I send to you become part of your legal record. I prefer to use email and/or text messages only for administrative purposes such as arranging or modifying appointments. In addition, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Twitter, etc). I believe adding clients as friends or contacts on these sites may compromise your confidentiality and our privacy, in addition to unnecessarily blurring the boundaries of our therapeutic relationship. Please be aware of the risks to your privacy if you have GPS tracking or "My Location" services enabled on your device, and you intentionally "Check In" from my offices.

Termination of Therapy
Clients have the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, I will generally recommend that clients participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another provider by offering referrals to clients.

Signatures Verifying Agreement
Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms as long as you are receiving services from me.

______________________________	______________________________
Client name – printed	Client name – printed
______________________________	______________________________
Client Signature	Client Signature
______________________________	
Date	